EMS ADVISORY COMMITTEE MEETING
MINUTES
MARCH 15, 2004
BISMARCK ND

Members Present: Tim Luthlie MD, Cheryl Flick, Dan Ehlen, Donna Pretzer, Janelle Pepple, Raphael Ocejo MD, Nancy Capes, Neil Frame, Mark Weber, Alan Runck, Darleen Bartz.

Department Personnel Present: Arvy Smith, Carol Eisenbeis.

Guests: Todd Porter.

Welcome: Darleen did introductions and welcomed everyone.

Darleen thanked everyone for participating in this last minute call.

Darleen gave a history of Air Ambulance rules. The first attempt to get legislation in place for air ambulance in ND was in 1991. It wasn't passed. It was discussed again at 1999 session but wasn't until 2001 session when the concept was introduced again on the senate side as an amendment. Then the Health Department was given the authority to license air ambulances. The language and statute that was passed in ND century code section 23-27-02, definition of emergency medical services was the statement that emergency medical services includes, BLS ambulance services, ALS ambulance services, air ambulance services and QRU services. This was the first time air ambulance was included in statute.

Based on this information the Health Dept staff moved forward with rule making by contacting other states and national groups to determine what the standards were. It wasn't until October 3, 2002 that the rules went out for public comment following approval of the Health council to take this step. The public hearing was December 17, 2002 with a comment period of 30 days past that time. All comments were considered and recommended changes were proposed to health council at the February 10, 2003 meeting. The rules were adopted by the Health Council at that time pending the legality review by the Attorney Generals' office. The request went down to the review in May 2003. The rules were adopted by health council at the June 10, 2003 meeting. They were published and went into effect with an effective date of August 1, 2003. So since then we have had rules to license air ambulances. The rules were presented at the legislative rules committee on November 19, 2003. At that time concern was expressed by Todd Porter regarding portions of the rules dealing with hours of operation and staffing. The legislative rules committee directed that we take the concerns back and come up with a compromise to address them and return to the next legislative rules committee meeting and report outcome of the changes. The next legislative rules committee meeting is scheduled for next week so they will report on the outcome of the changes.

Since then, however, the Department of Health formed the Emergency Medical Services Advisory Committee. The decision was made to get input from this group to seek recommendations for any changes that would come up in these rules. The meeting was held on January 15, 2004 and the issues of availability and staffing of air ambulances were discussed at length by the committee. The concern regarding the staffing of the BLS air ambulance service and the hours of operation were resolved during this meeting. The committee also came to a resolution regarding ALS air ambulance services and provided a recommendation regarding what should be minimum staffing requirements. After this meeting, Tim and Darleen met with Dr. Dwelle and Arvy Smith who gave approval to take changes to the Health Council. Health Council approved the changes. We thought the recommended changes were then ready to go back to the legislative rules committee, however were then informed that the proposed changes still did not meet legislative intent of that statute. Since then, Darleen and Tim have spent time reviewing minutes from legislative session of 2001 and visiting with legislative council, working with Dr. Dwelle and Arvy as to the direction to go with rules. Darleen then turned the meeting over to Arvy Smith to discuss further action on the rules.

Arvy explained that she is not in the medical field, but was in the accounting and administrative field, so she didn't intend to second guess anyone's opinion. The rules that were recommended by this committee's last meeting were not consistent with legislative intent. Legislative intent has the force of law so we attempted to come up with some compromise to get us past this. It is very likely that legislation will come up that will change this to what this group has recommended. Our concern is that we have had some discussion with legislators and there is a concern that the rules as recommended by this group will not pass and then we will be in a situation where we will not have rules regarding Air Ambulance services. Our concern is that in trying to do what is best for the public health that is not the way we want to go. The only area of contention yet is the issue of number of care providers that need to be present on an ALS Air Ambulance transport. This committee recommended it be a pilot plus two unless the sending and receiving physicians agreed that the pilot plus one would be appropriate. It is our understanding that an acceptable compromise would be to change to a pilot plus one unless the sending and receiving physician agrees that two plus a pilot is necessary. This would get the proposal off center and through the process. Arvy stated she was encouraged by legislators to bring this to the committee to see if this would be acceptable, and was encouraged to bring legislation forward to get this on the agenda for 2005, and to let all constituents hear both sides. So that is what we are planning at this point to resolve this. We wanted to present this to you upfront and see what your thoughts were and give you a chance to express any concerns or offer suggestions. Arvy did say they had never gotten a feel for how often a pilot plus two was necessary versus a pilot plus one so would encourage that an attempt was made to gather that information as we move forward to support this case one way or another. Arvy then opened up the meeting for discussion on this matter.

Discussion:
Commenter - What is the difference between pilot plus one care provider for ALS versus pilot plus one for BLS? There doesn't seem to be a distinction, so why are we even having this discussion? Maybe we should just take ALS for Air Ambulance out of the equation.

Darleen – There is a difference between ALS and BLS air ambulance requirements. The difference between the ALS and BLS air ambulance is that the ALS has to have 24/7 staff availability and the BLS air ambulance does not have this requirement.
For BLS air ambulance the minimum is one primary care provider. A primary care provider means a qualified provider responsible for the care of the patient while on the air ambulance run. What we had looked at during the Advisory Committee meeting was that the difference between ground BLS and ALS ambulance services was that the driver in an ALS ground ambulance was also required to be a qualified provider. With air ambulance we were looking at the flex up so that if the decision was made that two qualified providers were needed, the physician would order the second person on board.

Dr. Luthlie- This seems to be a market place issue. If the purpose here is to represent quality of care, I think that to be advanced life support does require that another person be available besides the primary care giver. Otherwise it seems to be a cost saving issue to only have one provider on a transport. What we've done is change this so it would pass any legislative reviews. So, it sounds like our hands are tied.

Darleen – When they are talking about the definition of the primary care provider, I am reading the same definition for BLS and ALS. The main difference in between the ALS and BLS levels is the 24/7 required by the ALS requirements and the less than 24/7 requirement for BLS. The ALS also provides an option to the physician to say we need two people and to flex-up.

Commenter – Where did you find the legislative intent so we can take a look at that?

Arvy – We didn't see any specific language regarding it. We would have had to go back to a previous session it appears, however, when we spoke to legislators they were adamant that what this group recommended was not consistent with their conversations and commitments to their constituents.

Commenter - What was it?

Arvy - They would not make it so strict that it would rule out certain providers from being a part of this. Todd, is that accurate?

Todd – Yes, that was the primary concern of the senate during their debate on this bill, that the rules would be so restrictive that rural providers or anyone coming in to be a provider would not be able to do so because of the level of restrictions and that they (the senate) wanted the least restrictive guidelines and then let basically market place play it out from there.

Commenter - Isn't licensure itself a restriction?

Todd – Yes, that was why it was so hard over the last ten years to even get them to consider it. The basic argument was that we don't have a license now and things seem to be going okay so why should we even put one in place? That was the other historical fact as to why nothing was put in place over the past ten year period.

Darleen – Part of what we did was met with Tim Wiedrich who was the past director of Emergency Medical Services. He had the ability to recall what took place during the 1991 and 1999 sessions. We obtained copies of everything that pertained to this during the 2001 session. We could not find a lot written documentation related to the intent so Tim Meyer went to the library and listened to tapes for hours of the 2001 session. All we have is the summary notes from the clerk regarding the discussion. We did not go back to 1991 or 1999, however, this older information could not be used to determine the intent of the 2001 session so we didn't do this. What we had to go on was the clerk's written summary, the tapes, and visiting with the legislators who were there at the discussion. Rep. Porter was the person who actually added the amendment and it was discussed on the senate side.

Arvy - Tim W said the bigger part of the intent came out of the 1999 session and the bill failed. Tim felt that having some rules was better than what was there before so it is a major accomplishment to be at that point. We may just need to go this route for the time being.

Mark – What is the purpose of licensing if you can't set standards?

Arvy – To distinguish between ALS and BLS. I understand the payment is the same.

Darleen – It does give us the ability to look at what equipment is on board, and to have at least some minimum…

Mark – Isn't that restrictive also? If they are licensed for ALS they have carry a monitor and drugs, isn't that restrictive?

Darleen – The statute that was passed identified certain areas that we need to address. Staffing is something that we do need to address, the part that is tough is that it needs to be consistent with the intent. The statute that came out of the 2001 session also indicates that the rules adopted by health council need to address the time the operator's service will be available, training standards for operation personnel, equipment, fees, number of personnel required for each run, and other requirements necessary to carry out the intent of the chapter. When we do rulemaking, those are the minimum requirements that must be addressed. We have addressed and reached consensus on all of them except for the staffing. We have been given the impression that unless we go with the legislative intent regarding staffing, they will void the whole air ambulance portion.

Mark – The intent is to not make it so restrictive that people can't participate in business. Now you are making it restrictive that they have to have a license that they have to be open so many hours, that they have to carry a monitor and certain drugs, and what's the difference if you restrict those areas and not the staffing? You are still making it restrictive with these rules, right? I don't understand.

Arvy – Staffing is the one that puts it over the edge.

Commenter – Why did they ask an opinion of that if they have already made up their mind and what we decide doesn't make any difference?

Arvy – I know this is a tough issue.

Commenter – Are you waiting for a rubber stamp so that we give you what you want?

Darleen – No, I don't agree with that comment. We are not coming to the committee to ask you to change your recommendations. Your recommendations are sound for patient care and we came to your for your expert advise. We wanted to let you know what we foresee will happen if we go that direction and to give you an understanding that we need to change the direction even though we think it is critical. We want feedback on putting together testimony on going back to the legislature. Would you be comfortable in the department making a statement what the recommendation of the committee was and to give them what the recommendation was and that the department was in support of the committee's recommendation, however, this did not seem to be consistent with the intent so we have had to modify the regulations consistent with the intent.

Mark – I don't see how it can be. If the intent was not to restrict so people can do business, then why license? Why set standards? Or if you are going – something is better than none. I didn't see anywhere that the intent was to have one person on there. The intent was not to restrict it so people couldn't do business. Either decision here, license and restrict the time, equipment, and level of that provider, or not – it's still restrictive, isn't it?

Arvy – Yes, the trouble with legislative intent is that you do not get the level of detail. Things get passed and then we're faced with putting in rules but there is not sufficient detail to pick out every one of those points so we need to put something in place. Apparently, all those other factors are fine but this thing puts it over the edge. Right or wrong, this is the situation we are in.

Mark – Do they document legislative intent?

Arvy – Not always at that level of detail. And I don't know that the discussions were at that level of detail.

Mark – So if they don't document at that level of detail, how can they come back and say now, Oh by the way, it was one provider that wanted it. We can't do that anywhere else

in life, can we? Oh by the way, this is what I meant. We can't do that. So then what you are saying, no matter what we decide, they are going to do it that way. Right? They are going to say, no we are going to throw out that rule, and it's going to go to one provider.

Darleen – The option is for the committee to be able to decide on what kind of legislation we want to propose for next session so that we don't get to this point and get bumped out again. We need to look at what legislation to put in place, if it should go through as a department bill even knowing that as a department bill it may or not make it, or do we go out and find a legislator to introduce the bill on behalf of the committee, giving us more of an assurance that it would get in. We are not being cut off without options, we can take next steps.

Mark – I know but that takes so much time and effort.

Darleen – I know it is going to take time and effort.

Mark – Does anyone know of any businesses out there that have voiced their opinion against this?

Darleen – I am not aware of any and the ones we have contacted, we have tried to contact every air ambulance service or potential service, the ones that have not been able to meet have been due to not meeting FAA requirements that has put them out of business.

Mark – So if there is nobody complaining, and the intent was not specified for one provider, why are we spending all this time here for? I don't understand that.

Arvy – As recommended by the committee, they will not pass.

Mark – So why are we here? Why don't they just make up their own rules?

Dr. Ocejo – It doesn't make any sense. We set up what we consider to be the best standards for care and just in order for us to have licensure we have to compromise. What is the point in having a committee like this?

Arvy – I know that is frustrating. As Darleen pointed out, we are not asking the committee to change their recommendation. We can acknowledge that recommendation as we go through and present information to the administrative rules committee. Our alternative is to present these rules and they will likely fail.

Dr. Luthlie – I guess it think that recommending a good rule would certainly make more sense and having them go down in flames, and not compromise. I don't think it is compromise as much as caving in and recommending what I would interpret as a bad rule just so we can say we recommended a rule and they got passed. I would rather have a good rule go down in flames than have a bad rule go through just because it went through.

Arvy – But if these rules don't pass, there will be a lower standard of care than if they do.

Dr. Luthlie – A lower standard than one person? They would be able to fly with just the pilot?

Arvy – A pilot plus one.

Dr. Luthlie – That's about as low as you can go, isn't it?

Arvy – No, there could be no rules.

Dr. Luthlie – And fly with just the pilot.

Arvy – Yes.

Dr. Luthlie – Well, that's not much different. I don't know of any company that would stay in business flying with just one. You mean just the pilot.

Arvy – There would be no rules regarding 24/7, regarding any of this.

Dr. Luthlie – So if we don't want to change this part, they can't just change parts of ours?

Arvy – They could hold the air ambulance rules, I don't know that they would pull out a piece of it.

Darleen – We could possibly recommend pulling out the portion on staffing.

Commenter – If we don't continue on with this, and they completely pull it out, then we are starting at ground zero, aren't we? At least now we are ¾ to 7/8 of way there.

Darleen – When we spoke with Tim Wiedrich on this, his bead on it was not to give away the whole ship for one small portion. His thought was to get the rules on board and to operationalize it and tweak the rest later. What we have gotten from our conversations with legislators is that if this gets wiped off the table now, our potential for getting it back on the table will be much slimmer. If we just go in to tweak a small portion, we will have a much greater potential for success. Tim had advised us to be careful about what we were willing to throw away.

Mark – It doesn't matter what we decide anyway, right, they will do what they want.

Arvy – They have the authority to suspend the rules.

Dr. Ocejo - The issue for us is decide, because it appears to me that we are being muscled one way or the other, what is a compromise from our point of view so that we can at least have some standards. If we are to look at it that way and accept that it is

going to be one provider and a pilot, it has to be in there the capability to provide a second provider if the physician requests it.

Darleen – Yes, that language would be incorporated in there. If one or the other physician or if they agree that there needs to have two providers, by rule that would need to be provided. The difficulty is that at the point when calling an air ambulance, how many physicians would think to make a decision regarding the staffing? This is not something that physicians are used to considering. When they request an air ambulance, they believe they are getting an air ambulance with the appropriate staff. On an interim basis if we go with one and have it written in rule that we can go up to two based on the discussion of the physicians, there would need to be education to the physicians to let them know that they would have to say there needs to be two on the transport.

Commenter – What was proposed by the committee did have a compromise in it, that it could go down to one if both physicians agreed. That makes more sense because at that time, you are not in an emergency situation. If you are making a transport from Bismarck to Rochester because someone is having surgery the next day rather than when you have a transport from rural North Dakota to Fargo because you have an accident situation. You are right, we don't think about staffing or equipment when we are in the trenches.

Darleen – The bottom line is that we have been informed by legislators that if it goes back in that form, they will kill the rules.

Mark – My question to the legislators is how can they kill this, when they do not want to put any rural providers out of business, when none of the providers are complaining about it, how can they come back and say well we, people who know nothing about medicine or patient care, think that we will put people out of business when nobody is complaining about it. How can that happen?

Al – What we have to consider is when this first pushed through to get it passed.

Mark – I understand the compromise, and I don't have a problem with compromise.

Al – What I am saying is as far as legislators, I think the whole thing is a lack of knowledge about what is going one. Otherwise there wouldn't have been a problem in pushing this through in the first place had the legislators known what is going on. My understanding is that it took an act of God to get it through. Now we go out as an association and educate the people, legislators as to what we need.

Mark – Why can't this be done now?

Commenter – Because this is government. It takes a lot more work.

Commenter – Why don't we just take all restriction out if their intent was to make it so that basically anyone with a plane able to transport somebody.

Arvy – But that's not in the best interest of public health.

Commenter – That's why we put the recommendations in in the first place, because of quality patient care. But now they want to change that based on some ambiguous intent that really isn't spelled out. So they said they're going to kill it, yet they don't want to listen to quality of care issues.

Todd – One of the things that you have to keep in mind is that a lot of this process, whether you agree or not, if you took the existing ground ambulance regulations in front of the legislature today, that require and EMT basic in the back of every ground ambulance, that you would have a hard time convincing the legislature that that was a good idea. They would tell you that they can't get people to do it in rural North Dakota. In the whole scheme of things, they would tell you that they would rather have an ambulance show up in rural North Dakota with on one trained than no ambulance at all. And if you take that to every other level of what is happening in rural North Dakota, they would tell you that over the past ten years or forever, looking back, the state and system functioned just fine without regulation, now why all of a sudden do you think that you need regulation when, the big question is was this broken, was there a detriment to public health, and was there a problem? And they would come back and tell you, no there wasn't. Because, we have not heard of any problems out there with air ambulances. So there would be no faulting them without a problem. That was the default, and that was the argument over the ten year period was that we don't need regulations as it is not broken.

Commenter – So as a legislator, why would you turn to professionals who do this on a regular basis and just go with there recommendations?

Todd – Because this committee and that recommendation wasn't in place at the time of this being passed. And it wasn't in place at the time of the public hearing before health council. This committee is an afterthought of the whole process. And while it is great input and a great committee for the future, it wasn't in place at the time. There wasn't anyone from the air ambulance side of EMS that even testified at the public hearing process at the legislature. There are three or four states that touch North Dakota that have minimum staff like the Health Department is now recommending that we have in North Dakota as a minimum. The whole concept of the legislature is that the mood of the legislature is that we as a state set minimums. The marketplace decides where it goes from there. We don't come in and take things such as EPA and exceed what the federal minimums are. We match those federal minimums and let it play out from there.

Commenter - So what are the federal minimums or recommendations by flight associations for the minimum requirements for ALS air transport?

Todd - Sure there is, there is even an accreditation system in place for air ambulance that even exceeds what the committees recommendations are.

Commenter - So what are the national recommendation, Dan do you know?

Dan - Yes, it's two.

Todd - From the accreditation process, there is nothing from the federal government, it is a state by state situation.

Commenter - So the standards of care in states surrounding us requires…

Commenter – It depends on which states you want to pick, some are two, some are one

Commenter – Which ones are one?

Commenter – Wyoming, Nebraska, and Montana are one.
Minnesota and South Dakota are two
Colorado does not have anything in place.

Darleen - Tim Meyer had contacted most all of the states and the EMS Directors Association and it is a mixed when you are talking about staffing. I believe his results showed that almost 50% of the states were requiring 2 staff for ALS runs. But then there were still states that had no licensure and some states that required one.

Commenter – So why wouldn't the legislators go with two of the three states that surround us and the minimum requirements set by the organization that accredits air ambulance services.

Todd - Accreditation has never been considered to be a minimum. They are never at where regulatory minimums are. I know how this was sold to the legislature to get the law changed in the first place. You can be mad and blame me, you can stomp your feet, I don't care. My integrity of how I sold this is all I am concerned with. As far as regulations are concerned, I don't feel regulations are going to change the standard of care of air ambulances in North Dakota because there are only two fixed wing providers and two helicopter providers in North Dakota and all are already meeting and exceeding the minimum standards and the standards the committee recognizes. But it wasn't the way it was sold in the process and that bothers me.

Mark – I'm not mad or stomping my feet. I'm just frustrated with why our legislators would make us go through all the work again to redo the bill when everyone is already meeting the standards and no one is complaining about it.

Todd – Because of the way it was sold during the process.

Arvy – It was a fair hearing issue. If it is the right thing to do, and it goes through a fair hearing, it will go our way.

Al – I worked on 9-11 several years ago. Our legislators didn't know anything about 9-11. I feel that this committee or any committee should educate the legislators ahead of time and that will solve a lot of problems. They hear a lot of legislation and they can't

know everything, so if we can educate them on air ambulance and the minimums for staffing they will understand where we are going. Education to the legislators in the number one issue, I think.

Todd – Absolutely, however, you have to understand that this was not brought in as a stand-a-lone piece of legislation. It was attached to an already existing bill that was going to rewrite EMS as a system wide approach. There was not a room full of providers or representatives from the ND EMS Association that was pushing this. It came from the department and it came with my name on it, and it was put through the process. It didn't come from the industry in the first place.

Mark – Todd, do you know if the committee that reviewed this legislation contacted the Association at all?

Todd – What committee are you talking about?

Darleen – Derek Hanson was present at that meeting representing the EMS Association. His comments were in support of the bill written and the amendments as presented. Rep. Dale Severson was also there as one of the sponsors with Rep. Porter. Tim Wiedrich with the Department of Health was also at the meeting. Several other legislators were also present at the meeting. Glen Thom representing the Respiratory Care Association was there to present some amendments.

Todd – Was he there to oppose the bill? He wanted us to set up a Board.

Darleen – The meeting was March 14, 2001. Several others were also present; however, the minutes of the meeting are very minimal. One concern was identified in regards to the minimal documentation as to what was the intent of the legislation. The only ones that know are the ones that presented the amendments. So, the EMS Association was represented at the discussion.

Arvy – So, like I indicated, we don't want to change the committee's opinion or recommendations. However, because we feel it is in the best interest for public health, we are going to have to go in this manner. It is about a year until the 2005 session is in full swing and then we will be able to present it and give it a fair hearing and move ahead. We do need to bring it to the Health Council yet, they did approve the last version.

Darleen – We are looking at bringing it to them either Thursday of Friday of this week. We are looking at having a teleconference call. If any of you are interested in participating in the call we can get the information to you – it is a public hearing.

Mark – But it doesn't matter. The intent is one person in the back of the air ambulance as per Todd Porter, so what's the difference. The health council's already approved it once.

Darleen – They have already approved it with two going down to one.

Arvy – They have approved two going down to one. Now we are going to ask them to ask them to approve one going up to two.

Mark – They've approved it?

Arvy – The health council has to approve rules before we take them to the interim legislative rules committee.

Commenter – And they have already approved two?

Arvy – The health council had approved two.

Commenter – Has the interim committee met on that already?

Arvy – Not on the two, they met on the earlier version.

Commenter – Then how do we know that it will not pass the interim committee?

Arvy – We have had some discussion with several legislators that make up that committee – rural, conservative, against added regulation…

Commenter – So they have decided before they have seen anything from us anyway?

Arvy – Based on their history with the bill, they have and the commitments they have made to their constituents in even getting this on the agenda.

Commenter – When is the next interim committee meeting?

Arvy - The next interim meeting that will hear this will be on Wednesday, March 24 at 9:50 a.m. We have to take this to health council first.

Mark – Basically if we didn't know that their decision was already made our decision would be to stick with the way we have it now, but because we already know what their decision is – even though they haven't met yet – we pretty much just have to give in.

Commenter – And this committee is made up of a cross-section of representatives from the medical field and ambulance services and we decided that two is better than one, and the legislators are going to say that they are not going to take that into consideration.

Todd – But then they go back to legislative intent.

Arvy – And the commitments they made to their constituents. It is better than not getting any rules.

Commenter – If this committee would have been formed at the time they made these rules, I don't think they would have had any problem with it. But the fact is that the

promises and things were made and before this was even brought up and before this committee was formed. I don't think any one here questions that it is a standard of care issue. But it goes back to a legislation issue.

Arvy – This particular committee here that you are on was put together to advise us on emergency medical issues across the board. It was a total coincidence in timing that at the time we thought we needed to put this committee together, it fell in with this air ambulance issue and it happened to be the first issue you have taken on. This will go away and there will be several other issues that you will deal with. No, it won't go away…it will be discussed at other meetings.

Mark – So why do we have to vote on this recommendation because we don't need to?

Commenter – This gives us insight into what we have to do a year from now.

Mark – We already know what we have to do a year from now, it has already been decided. So the EMS Advisory committee doesn't have to take a vote on this.

Darleen – What we need to be looking at is our next steps. Realize that we are not asking you to change your minds. Everything that we did was for quality of care which we thought was two versus one. None of us have changed our mind regarding that. The next step is to decide upon what kind of legislation we put in place, where do we go, and what kind of support will we get from the committee to go out there so when we go to the legislature so that when we get to the session, we can get it passed.

Commenter – It's frustrating.

Darleen – Yes, for many of us it is.

Commenter – It doesn't make sense. Politics.

Darleen – There isn't a single member on the committee that supports the change in direction.

Dr. Ocejo – I guess the committee will have to eventually discuss what is better – bad or worse - because none of us are convinced that it is best. We have to decide what it is going to be, we have to choose.

Darleen – Yes, that needs to be apart of the discussion. As this group becomes recognized and legislators realize that we have a significant amount of knowledge, when we say something that is truly important, we will gain credibility.

Mark – I understand that, but right now we don't really have to do anything.

Darleen – This is more information sharing – that we are between a rock and a hard place. What we are moving forward with is not necessarily what we choose to move forward with, but we don't have a lot of choices if we want air ambulance rules.

Mark – It is already on the table, the advisory group doesn't have to do anything. It has already been voted on. And this is the best we can do for now.

Darleen – For the short term.

Mark – I know we have work to do. For right now, this particular situation is a done deal. I think we need to take Al's advice and educate the legislators.

Darleen – Yes, we have also discussed that within our section – how do we get out there and provide education.

Arvy – The health council is a public meeting and anyone can attend and present comments.

Mark – We have been told that it will fail, so it doesn't matter what we say at health council.

Darleen – Thank you to the committee members and Todd for attending and participating in this meeting. The comments from this committee are highly valued by the department and we are looking at taking this the next step for new legislation. In the meantime, we have a lot of work to do to educate so that we can get it passed in the next session. Todd, thank you for your willingness to be a sponsor for this bill in the next session. We will not have a March 18 meeting of this committee. We will get back to you with other quarterly dates. Thanks again for your participation